Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $27,691.22, for dates of service 05/26/01 and extending through 05/31/01.

   b. The request was received on 05/24/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. TWCC 62 form
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/01/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 07/02/02. The only response from the insurance carrier received in the Division was the 3 day response dated 05/30/02.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

> "The Acute Care In-patient Fee Guideline states the 'Stop-loss method' of reimbursement is to be used 'in place of and not in addition to the per diem based reimbursement system. *See Tex. Admin. Code Section 134.401(C)(6).* As the total charged for the hospital admission exceeded $40,000, the entire admission is to be reimbursed using the 'Stop-Loss' reimbursement factor of 75%. However, the Carrier applied the 'per diem' rate of reimbursement…As the Carrier has only forwarded payment of $6,708.00 towards the 'Stop-Loss' reimbursement portion, the facility is requesting the remaining $27,691.21 **plus interest**…The Carrier forwarded payment in the amount of $14,317.00 of which $7,336.00 was reimbursement for the 'carve out' billed charges."

2. Respondent:

> There was no response found in the case file.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 05/26/01 and extending through 05/31/01.

2. The Provider billed the Carrier $47,688.61 according to the submitted Table of Disputed Services, for the dates of service 05/26/01 and extending through 05/31/01.

3. The Carrier made a total reimbursement of $14,317.00 according to the letter submitted June 25, 20021, for the dates of service 05/26/01 and extending through 05/31/01.

4. The amount left in dispute is $27,691.22 according to the submitted Table of Disputed Services, for the dates of service 05/26/01 and extending through 05/31/01.

V. RATIONALE

Medical Review Division's rationale:

> The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $47,688.61. Per Rule 134.401 (c)(6) (A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. Per the EOB, the Carrier paid $7,414.00 for supply/implants. The Carrier denied "Hospital Services" with the denial code of "F-SUBMITTED SERVICES ARE CONSIDERED INCLUSIVE UNDER THE STATE PER DIEM GUIDELINES." It denied the implantables and blood/admin as M-REDUCED TO FAIR AND REASONABLE." In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, which is indicated in the Medical Fee Guideline since the rule states this method is used only for the per diem reimbursement methodology.) There was no documentation submitted by the carrier to indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the hospital. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

The blood/admin was denied "M-REDUCED TO FAIR AND REASONABLE." There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for blood/admin in the same geographical region as the hospital. The carrier must determine what is usual and customary for these items in that region and billed by other facilities. Therefore, the blood/admin will be determined in the total amount billed at the 75% stop-loss.

The hospital has billed its "usual and customary charge" of $26,960.00 for the implantables. The carrier has not submitted evidence of what is usual and customary in that region for these items.

Therefore, the total reimbursement will be calculated in the following manner:

Total charges are $47,688.61
Multiply the audited charges of $47,688.61 x 75%
$47,688.61 x .75= $35,766.46
The carrier paid $14,317.00
$35,766.46 - $14,317.00 = $21,449.46
Therefore, additional reimbursement **is** recommended in the amount of **$21,449.46**.

The above Findings and Decision are hereby issued this 8th day of November 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $21,449.46 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 8th day of November 2002.

David R. Martinez
Manager Medical Dispute Resolution
Medical Review Division

DM/mb